

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-043729

STATE FILE NUMBER

Registration District No. 144 Primary Registration District No. 5562 Registrar's No. 140

FILED DEC 13 1963

1. PLACE OF DEATH a. COUNTY <u>Iron</u>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Franklin</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Arcadia-Rural</u>		c. CITY OR TOWN <u>St. Clair, Mo.</u>	Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>The Home for Aged Baptists</u>		d. STREET ADDRESS (If outside, give location)	Reside on Farm Yes <input type="checkbox"/> No <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First <u>Martha</u> Middle <u>Adeline</u> Last <u>Colter</u>			4. DATE OF DEATH Month <u>Dec.</u> Day <u>9</u> Year <u>1963</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>11/16/77</u>	9. AGE (last birthday) <u>86</u>	IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Her home</u>		11. BIRTHPLACE (City and state or country) <u>St. James, Mo.</u>	
13a. FATHER'S NAME <u>John B. Skyles</u>		13b. MOTHER'S MAIDEN NAME <u>Elizabeth A. Osborn</u>		14. NAME OF HUSBAND OR WIFE <u>Teed Colter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>			16. SOCIAL SECURITY NO. <u> </u>		
17. INFORMANT <u>John H. Burney, Ironton, Mo.</u>			Address <u> </u>		

18. CAUSE OF DEATH (Enter only one cause per line) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u>
Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Cerebral arteriosclerosis</u>		<u>5 years</u>

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
---	--	--

19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour <u> </u> a.m. <u> </u> p.m. <u> </u>		Month, Day, Year <u> </u>	
20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION <u>Ironton, Missouri</u>	
21. I attended the deceased from <u>3/18/62</u> to <u>12/9/63</u> and last saw her alive on <u>12/6/63</u> Death occurred at <u>5:25</u> P.m. on the date stated above, and to the best of my knowledge, from the causes stated.		22c. DATE SIGNED <u>12-10-63</u>	

22a. SIGNATURE <u>Marion C. Chene</u>	(Degree or title) <u>WB</u>	22b. ADDRESS <u>Ironton, Missouri</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>removal</u>	23b. DATE <u>12-11-63</u>	23c. NAME OF CEMETERY OR CREMATORY <u>City Cemetery</u>
23d. LOCATION (City, town, or county) <u>St. Clair, Mo.</u>		(State) <u> </u>

24. FUNERAL DIRECTOR <u>White Funeral Home, Ironton Mo.</u>	25. DATE RECD. BY LOCAL REG. <u>12-11-63</u>	26. REGISTRAR'S SIGNATURE <u>Mr. Aris Jones</u>
--	---	--

(Licensed Embalmer's Statement on Reverse Side)

DO NOT WRITE ON THIS STUB

AMENDED

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

USE BLACK INK OR TYPEWRITER RIBBON

DEC 18 1963

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____, Student Embalmer No. _____

— working under my personal supervision.

Student _____

Signature of Student Embalmer

Signed Russell J. White

Licensed Embalmer No. 3012

P. O. Address San Antonio, Tex.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.